

Name of Board/Committee (In Public)

Item 2.4

Subject: The first year of the High Risk Cardiac MDT
Date of Meeting: 05th March 2019
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Purpose of Report: For Note

BAF Ref	Impact on BAF
1.1	This report provides assurance on the effectiveness of the High Risk Surgical MDT that was established 12 months ago as part of the Surgical Division's strategy for improving outcomes and reducing mortality. The paper complements the previous reports to Board on mortality, including the mortality outlier alert investigative work.

1. Executive Summary

The High Risk MDT was set up to discuss patients who may not have fallen within the remit of the established MDTs. This primary analysis suggests that the meetings are well attended, and that patients are presented for a variety of different reasons. The outcomes of the patients treated surgically compare favourably with those treated with other modalities.

2. Background

Until January of 2018 there was no formal MDT to discuss patients who were considered high risk for surgery. The individual MDTs were available for single pathologies or treatments (eg coronary disease, mitral, TAVI) but were not necessarily the optimal forum for all patients. The High Risk Cardiac MDT commenced in January 2018 and had no specified criteria for which patients could be discussed.

Patients considered high risk are a diverse group: they may be considered high risk due to a high predicted operative mortality, a predicted need for prolonged ITU care, or due to the nature of the proposed surgery (eg a heavily calcified aorta that requires an alternative approach to the routine).

Patients discussed at the High Risk MDT over the course of January to October 2018 were analysed.

3. Main Content (*insert own para headings*)

42 High Risk MDT meetings were held in 2018, with a mean attendance of 11 consultants across all specialties. On average, there were 7 surgeons, 2 cardiologists and 2 anaesthetists at

each meeting. One hundred and thirty one patients were discussed, with 5 having a second discussion to examine further investigations recommended at the first meeting.

The analysis below includes only the 110 patients who had been discussed up to October 2018 as operative and follow up data was available for these.

Patients with reduced left ventricular function, respiratory disease, previous surgery, those requiring urgent procedures and those with peripheral vascular disease were over-represented in the High Risk MDT when compared to the whole surgical cohort. These factors are accounted for in risk prediction tools. 8 patients were discussed as they were considered to be frail, although only two of these had this measured objectively with a Frailty Score.

The patients were categorised according to the main reason for discussion at the MDT, although as this was done retrospectively, it may not be entirely accurate. The largest group was those who had significant co-morbidities which were expected to impact their peri-operative course, accounting for 28%. Only 10% of patients were discussed solely on the basis of their predicted surgical risk – suggesting that factors not included in the risk models played an important part in the decision making.

Up to half the patients were moved from one treatment modality to another after discussion at the meeting. This, however, was difficult to measure retrospectively as some were brought to the MDT as it was felt the original referral had not gone to the appropriate specialty.

In-hospital outcomes

The POCCU/ITU length of stay for those patients operated on was 7.8 days on average, with a total hospital length of stay of 16 days. There were 3 (8.1%) CVAs.

Discharge destination

78.9% of patients were discharged to their usual residence after surgery. 15.8% of patients were transferred to another hospital or care facility.

Short and medium term survival

In-hospital mortality for the surgical group was 5.3%, which compares favourably with their Logistic EuroSCORE of 10.5. The calculated 11 month survival was 85%, which was comparable to those patients who had cardiological intervention or medical management. These medium-term results will need validating when data on larger numbers of patients are available.

4. Conclusion

Consultant medical staff attended the MDTs and presented a breadth of opinions. All surgical consultants attended and presented at least one patient. Up to half the patients had a change in their proposed intervention after discussion at the MDT [It is difficult to know for certain what procedure was proposed prior to the discussion in some cases].

A large proportion of patients discussed at the High Risk MDT had factors outside of those considered in traditional Risk Scores which increased their surgical risk. Despite this, the observed early mortality was within an acceptable range. Furthermore, while the data is limited, the medium term survival also appears to be good. There was no difference between the predicted 1 year mortality between those patients treated surgically and those who had other treatment modalities.

5. Recommendations

- The Medical Director is working on an MDT proforma that can be used across the various MDTs to collect baseline data. This will allow continued monitoring of outcomes and decision making.
- Ongoing analysis should be performed to ensure short and medium-term outcomes are maintained.
- Objective measures of frailty should be more widely used.